LEGISLATIVE AUDITS

REPORT FOLLOW-UP

AGENCY: IDAHO DEPARTMENT OF HEALTH & WELFARE

On May 19, 2006, the Legislative Services Office released a Management Letter for the Idaho Department of Health and Welfare for fiscal year 2005. The Department was contacted on August 1, 2006, and this follow-up report addresses how the Department has responded to the 13 findings and recommendations contained in that report, as well as the four outstanding prior findings and recommendations.

STATUS OF RECOMMENDATIONS

FINDING #1 – Changes are needed in the criteria used to establish Medicaid eligibility under the Katie Beckett program.

We recommended that the Department undertake a thorough review of the criteria used to determine eligibility in the Katie Beckett program, and establish processes to monitor services provided to clients to ensure that an appropriate level of care is provided.

DEPARTMENT'S ORIGINAL RESPONSE – The Department believes that all Katie Beckett clients are eligible according to federal rules and the State Plan. They disagree that the Department should monitor all services provided for Katie Beckett clients. They acknowledge however, that the number of clients could be decreased by making the criteria stricter.

AUDIT FOLLOW-UP – This issue was submitted to the federal grantor for review and the Department is awaiting a response before taking any action.

STATUS – OPEN

FINDING #2 – Idaho is one of only two states without a certified Medicaid Fraud Control Unit (MFCU).

We recommended that the Department initiate a dialog with executive and legislative leadership to evaluate the merits of establishing a certified MFCU that could provide additional funding for investigating and prosecuting suspected cases of Medicaid fraud and patient abuse. We suggest that this dialog include the State Attorney General.

DEPARTMENT'S ORIGINAL RESPONSE – The Department recognizes the need to add additional resources for fraud investigations and agrees to participate in evaluating the need for a certified MFCU. However, they disagree that a MFCU would lead to financial benefit or increased investigations and recoveries. The Department believes that the decision to establish an independent MFCU is a policy decision for the legislature, the Governor's office, and Department heads.

AUDIT FOLLOW-UP – A bill to establish a certified MFCU was introduced in the fiscal year 2006 legislature (HB 668) but was held in the Senate Health and Welfare Committee to allow more time to study the issue. The Department continues to believe that the decision to establish a MFCU is a policy decision for the legislature and the Governor's Office, and will contribute to the discussion as recommended.

The Legislative Audit staff also met with members of the State Attorney General's Office to discuss the efforts taken to evaluate establishing a MFCU within their office. The Attorney General's staff is currently researching this issue to identify the requirements and changes needed to existing Idaho laws and rules for establishing a MFCU. They have also met with officials from the Nebraska Attorney General's Office, which established a MFCU in 2004, to identify the processes and challenges.

STATUS – OPEN

FINDING #3 – The process for identifying and recording private health insurance coverage of Medicaid clients needs improvement.

We recommended that the Department improve the processes and efforts to identify and record health insurance resources of Medicaid clients as follows:

- **Develop a retrospective review process for suspect claims, in order to identify insurance resources known by providers previously excluded from the process.**
- **Amend the contract to define a valid insurance resource as one where the coverage period overlaps the client's period of Medicaid eligibility. The Department should analyze all insurance resources added during the last year, and request a refund from the contractor for fees to add resources for clients who were not eligible during the insurance coverage period.**
- **Coordinate the establishment of an enhanced data match process with Idaho-based private insurance companies to improve the efforts to identify Medicaid clients having health insurance. This may require the assistance of the Idaho Department of Insurance and legislation to establish the Department's ability to access this data.**

DEPARTMENT'S ORIGINAL RESPONSE – The Department disagreed that insurance data is not pursued. They believe that insurance resources recorded do avoid cost or lead to recoveries. The Department is researching other states' laws regarding comprehensive insurance data.

AUDIT FOLLOW-UP – The Department has made progress with the following corrective actions:

- Some insurance data known by providers is not pursued. The contractor has made several changes to strengthen their processes, including adding new staff and holding weekly meetings to discuss and resolve issues.
- Insurance resources are recorded that have little or no possibility for cost avoidance or recovery. The Department maintains its original response that no corrective action is necessary.
- No comprehensive data match exists with Blue Cross or Blue Shield of Idaho. The Department is in the process of researching legislation in other states related to this issue.

STATUS – OPEN

FINDING #4 – Medicaid eligibility continues to be improperly determined, due primarily to the outdated automated system.

We recommended that the Department identify the processes and issues that cause Medicaid eligibility to be improperly determined. Corrective action is also needed to address payment processing errors reported in the Payment Error Rate Measurement Report. We also recommended that the Department continue to seek resources to replace EPICS.

DEPARTMENT'S ORIGINAL RESPONSE – The Department has taken steps to improve the quality and timeliness of Medicaid eligibility determinations. Modifications have been made in the EPICS system that will allow workers to more accurately select the correct coverage group for applicants. Modifications go into effect in April 2006 to renewal processing in the automated system.

AUDIT FOLLOW-UP – The Department has completed all of the corrective actions from the original response. The EPICS system modifications were made, the Medicaid waiver is being implemented, and the replacement of EPICS system has begun. The Department anticipates seeking additional funding during the fiscal year 2007 and 2008 legislative sessions to complete the replacement of EPICS.

STATUS – CLOSED

FINDING #5 – Essential edits in the Medicaid claims payment system are disabled and allow claims to be paid in error.

We recommended that the Department enable all essential system edits to ensure the accuracy of claims paid, and ensure that Medicaid is the payor of last resort when claims relating to injuries or accidents are submitted.

DEPARTMENT'S ORIGINAL RESPONSE – For the following reasons, the Department disagreed that essential edits were disabled.

- The edit that matches a client's name and number to Medicaid records was in test in January and February 2005, to determine the most effective way to handle mismatches. However, it was turned on March 1, 2005, and has been in place since that time.
- The edit that checks for "injury accident" claims is active. These claims are automatically "pended" for further review except for Medicare claims which the Department is federally mandated to pay as submitted.

AUDIT FOLLOW-UP – The Department has taken steps to apply the "name number mismatch" edit to cross-over claims from Medicare. These cross-over claims were not previously subjected to this edit and are the bulk of items identified in the audit. The review of injury-accident edits is still in progress.

STATUS – OPEN

FINDING #6 – The Healthy Connections Medicaid program is not cost effective for at least two of four eligibility groups.

We recommended that the Department reevaluate the Healthy Connections waiver and discontinue this program, or consider incorporating it into the State Plan to eliminate the need to justify cost effectiveness and eliminate the potential refund of program costs to the federal grantor.

DEPARTMENT'S ORIGINAL RESPONSE – The Department has undertaken a significant Medicaid reform effort that began in July 2006. The Healthy Connections program will no longer be a separate waiver and will be incorporated into the new State Plan.

AUDIT FOLLOW-UP – The Department submitted an amendment to incorporate the Healthy Connections program into the State Plan effective no later than October 2006.

STATUS – CLOSED

FINDING #7 – Efforts by the Child Support Program to recover Medicaid birth costs are not consistent.

We recommended that the Department pursue birth costs from all biological parents who are not included on the application for Medicaid assistance. Child support cases should be established for all clients and the reasons documented for not pursuing birth costs where appropriate.

DEPARTMENT'S ORIGINAL RESPONSE – The Department's Medicaid Division is reviewing this issue with program experts and the Deputy Attorney General, and will present options to director.

AUDIT FOLLOW-UP – The review of this issue by the Department is still in progress.

STATUS – OPEN

FINDING #8 – The number of child support cases with debt errors has declined but remains high.

We recommended that the Department enhance the efforts to review and correct child support debts. The Department should continue to pursue additional resources to address this issue in order to complete this effort within a reasonable timeframe, perhaps within the next two to three years.

DEPARTMENT'S ORIGINAL RESPONSE – The Department will continue to work on improving the accuracy of child support debt balances by auditing approximately 400 cases per month. The Department requested an additional $3.1 million in fiscal year 2006 to address this issue that the legislature did not fund. A similar request was made for fiscal year 2007 that was not approved by the Governor.

AUDIT FOLLOW-UP – The Child Support Program has improved the financial accuracy of cases by establishing Consolidated Units and standardizing the various processes. Each Consolidated Unit has developed, or is in the process of developing, processes and methods to improve performance.

Although improvements have been made to reduce errors, efforts to evaluate the accuracy of debts for all cases will still not be completed within the recommended two to three years, based on the current rate of case reviews.

STATUS – OPEN

FINDING #9 – Child care benefits are calculated on market rates and poverty tables that are more than five years old.

We recommended that the Department base the child care benefit calculation on current market rate surveys and federal poverty rates as required by administrative rule. Efforts to manage the growth in program costs should rely on appropriate processes to adjust administrative rules or other factors used to determine benefit amounts and client eligibility.

DEPARTMENT'S ORIGINAL RESPONSE – The Department disagreed that administrative rules require the use of current market surveys and poverty limits in calculating child care benefits. There is no federal mandate that the poverty limits are adjusted annually.

Raising the poverty rate to the current amount would result in an estimated increase in benefit costs of $2 million. Raising the market rate would likewise increase benefit costs by $1.5 million. The Department is currently considering raising the market rate and using the current poverty limits within the existing budget.

AUDIT FOLLOW-UP – The Department will propose two rule changes to the Idaho Child Care Program during the next legislative session. These changes are expected to generate a savings that will allow current market rates and poverty tables to be used.

These rule changes will limit student eligibility by establishing a work requirement and reduce the period of time in which a post-secondary student can receive benefits.

STATUS – CLOSED

FINDING #10 – Funds from the Temporary Assistance to Needy Families (TANF) grant are used for medical costs, foster care services, and other unallowable activities.

We recommended that the Department review all foster care costs paid with TANF funds to identify the amounts allowable under prior law, and amend the federal quarterly reports for the past year to accurately reflect the amounts. The Department should amend the current TANF State Plan to clarify the circumstances for which foster care costs are allowable for funding and develop new coding structure to properly report these costs in the future.

We also recommended that the Department reaffirm with staff the requirements for documenting family income and emergency conditions when authorizing services using TANF funds, and return $2,056 to the federal grantor for medical costs charged to the TANF grant in error.

DEPARTMENT'S ORIGINAL RESPONSE – The Department agrees that medical costs of $2,056 were unallowable, and these funds have been returned to the federal grantor. The Department will amend the TANF State Plan to fully identify the use of program services allowable under the 1993 State Plan, and describe the circumstances when foster care costs can be paid with TANF funds. In addition, the Department will reinforce the need to switch funding for foster care services promptly to sources other than TANF once the client has been determined eligible for Foster Care Grant program services.

The Department agrees that emergency assistance funds were used improperly, and will provide training related to this issue to all staff involved in the emergency assistance program.

AUDIT FOLLOW-UP – The Department has completed all of the corrective actions described in it's original response.

STATUS – CLOSED

FINDING #11 – Food stamp error rate continues to exceed the allowed percentage and will result in additional financial sanctions.

We recommended that the Department improve the accuracy of the eligibility process to reduce payment error and negative error rates to avoid additional sanctions and the consequences to needy families who are denied assistance in error. A renewed effort should be considered to seek funding to replace the outdated "EPICS" eligibility system.

DEPARTMENT'S ORIGINAL RESPONSE – The Department's corrective action plan to further reduce the error rate is a three pronged approach.

- To realize immediate results, the Division is reviewing all cases with benefits exceeding $300 prior to the release of these benefits. This activity was selected in federal fiscal year 2005, 41% of all errors were in cases with benefits exceeding $300. This activity is being funded by a reinvestment of the sanction.
- To achieve mid- and long-term sustainable improvements, the Division is taking specific steps to reengineer the business processes and food stamp policy to improve the initial application and application for recertification functions.
- The quality assurance data indicates that 60% of the errors occur in these two functions. To achieve long-term sustainable improvements, the Department now has funding and is reengineering and replacing the EPICS system.

AUDIT FOLLOW-UP – The Department has completed most of the corrective actions and reduced the error rate to within a 0.2% of the national average for federal fiscal year 2005. Efforts are continuing to further reduce the error rate and seek additional funding to complete these efforts and replace the EPICS system.

STATUS – CLOSED

FINDING #12 – Fees for mental health services are based on poverty rates that are more than 13 years old.

We recommended that the Department adjust the fees listed in the Community Mental Health Services administrative rules to current rates and federal poverty guidelines. We also recommend that the Department consider amending these rules to describe the method for determining the fees, rather than detailed values or fixed amounts, as a way to avoid the need for future amendments.

DEPARTMENT'S ORIGINAL RESPONSE – The Department will seek to change the rule so that it describes the scale method and refers to the current federal poverty limits. The rule change will exclude the detailed fixed prices for services that are covered under Medicaid and make reference to the Medicaid fee schedule. The Department will also update all fees not addressed by Medicaid.

This rule change will require a parallel change in the "Fees for Developmental Disabilities Services" as it uses the same poverty rates, sliding fee scale, and billing system as the Adult Mental Health Program. There may also be an impact to the "Rules Governing Family and Children's Services" that identifies fees for children's mental health services and includes the use of a sliding fee scale, based on 1998 poverty rates.

AUDIT FOLLOW-UP – The Department is currently evaluating the most equitable way to update and use the same schedule for all Behavioral Health Programs. Once that is determined, the Department will promulgate rules to implement the change.

STATUS – OPEN

FINDING #13 – Administrative rules for recovering certain types of Medicaid costs from parents are not enforced.

We recommended that the Department undertake a complete analysis of the legal and legislative requirements for recovering certain Medicaid costs from parents. This analysis should seek to resolve the issues of whether to amend or delete these rules, appeal the District Court's ruling, or request legislation to clarify the intentions or authority to recovery these costs from parents.

DEPARTMENT'S ORIGINAL RESPONSE – The Department has analyzed this issue in conjunction with the Deputy Attorney General and plans to review the statutory, legal, and administrative issues during the coming months to determine the appropriate resolution.

AUDIT FOLLOW-UP – The Department has rewritten these rules and deleted the requirement to recover certain Medicaid costs from parents, effective July 1, 2006. The revised rules will go before the legislature in 2007.

STATUS – CLOSED

STATUS OF PRIOR RECOMMENDATIONS

The following is the current status of the prior findings and recommendations that were open when the report was released.

PRIOR FINDING #2 – The Department has not yet taken steps to pursue absent parents for ongoing Medicaid costs.

We again recommended that the Department develop a strategy to pursue and recover Medicaid costs from absent parents. This strategy should include methods for identifying all absent parents and opportunities to incorporate the Department's existing efforts and information in pursing these individuals.

CURRENT AUDIT FOLLOW-UP – Guidance was received from the federal grantor, indicating that there are no federal requirements that states must pursue and collect Medicaid costs from absent parents.

The Social Security Act requires states to "take all reasonable measures" to identify and pursue liable third parties, but other reasonable measures are left to the discretion of the state, such as whether or not to pursue Medicaid costs from absent parents.

This guidance clearly allows the State to pursue absent parents for ongoing Medicaid costs, and we continue to believe the Department should evaluate this option and opportunities to recover costs from these liable individuals.

STATUS – OPEN

PRIOR FINDING #4 – Eligibility continues to be improperly determined in one-third of the Children's Health Insurance Program (CHIP) clients tested.

We again recommended that the Department review case files and remove ineligible clients from CHIP. Additional resources and renewed efforts are also needed to develop new automated systems and processes to limit the opportunity for recurring eligibility errors.

We also recommended that the Department negotiate a resolution with the federal grantor concerning the potential refund for the cost of providing services to ineligible clients.

CURRENT AUDIT FOLLOW-UP – The legislature granted the Department authority to fill 25 employee positions in April 2005, with an additional 25 positions approved for fiscal year 2006. The Department filled all of the authorized positions, and has resolved the questioned cost amount with the federal grantor.

STATUS – CLOSED

PRIOR FINDING #6 – No procedures exist to identify or pursue child support debts from the estates of deceased non-custodial parents.

We recommended that the Department develop procedures for pursing child support debts from the estates of deceased non-custodial parents through probate or other means. The Department should consider combining these efforts with the existing estate and probate recovery activities in the Medicaid program.

CURRENT AUDIT FOLLOW-UP – The Welfare Division is still looking for a possible solution. The Division attempted to identify a method with the assistance of Medicaid, but tests did not yield results. The Welfare Division is now working with the Health Division to develop another possible solution.

STATUS – OPEN

PRIOR FINDING #8 – The Department improperly used more than $1.8 million of the TANF grant funds for inpatient treatment costs and child care services.

We recommended that the Department comply with federal regulations by not charging medical services or child care costs to the TANF grant. Program staff should be notified that residential treatment placements that include any medical services are not allowable costs to the TANF program.

We also recommended that the Department contact the federal grantor to resolve the questioned costs and potential refund of federal funds.

CURRENT AUDIT FOLLOW-UP – The Department contacted the federal grantor and has resolved all questioned costs and related issues described in this finding.

STATUS – CLOSED